

UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

_____	)	
STEVEN McDERMOTT,	)	
STACEY McDERMOTT	)	
Plaintiffs,	)	
	)	
vs.	)	Civil Action No.: 04-CV-12253
	)	
FED EX GROUND PACKAGE	)	
SYSTEMS, INC.,	)	
Defendant	)	
	)	
and	)	
	)	
T.S. PRUITT,	)	
Defendant.	)	
_____	)	

**ORDER FOR PLAINTIFF STEVEN McDERMOTT TO EXECUTE A MEDICAL  
AUTHORIZATION FORM FOR THE RELEASE OF MEDICAL  
INFORMATION FROM NEWPORT ALLIANCE/NEWPORT HOSPITAL**

IT IS ORDERED THIS \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ that:

The plaintiff Steven McDermott execute the Newport Alliance/Newport Hospital  
Authorization Form, attached as Exhibit 1.

\_\_\_\_\_  
Justice of the Court:

01/18/2005 11:15 FAX 401 848 6009

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**NEWPORT HOSPITAL**  
*A Lifespan Partner*  
**11 FRIENDSHIP STREET**  
**NEWPORT, RHODE ISLAND 02840-2299**  
**(401) 845-1150 Fax: (401) 848-6009**

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION  
 MEDICAL RECORD DEPARTMENT/REMOTE MEDICAL OFFICES**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Newport Hospital to disclose and release to:

\_\_\_\_\_  
 (Name of person/place/institution)

\_\_\_\_\_  
 (Address)

The following confidential health care information about: \_\_\_\_\_  
 (My, my child's, my ward's etc.)

hospitalization and/or out patient examination/treatment:

\_\_\_\_\_  
 (Dates of treatment and/or specific information required)

for the purpose(s) of: \_\_\_\_\_

(Reason for request, i.e., how is information to be used)

Please check one: I hereby

☐ Consent

☐ Refuse

to the release of confidential information concerning: mental illness, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results.

I understand that my records are protected under the Federal Confidentiality Regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

Any information to be released or received that is authorized by my consent evidenced by this document shall not be given, transferred or relayed in any manner to any other person, either in an individual or representative capacity, without an additional written consent.

I understand that I may withdraw this consent by giving written notification to Newport Hospital at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

I confirm that I have read the above, fully understand it and have no further questions.

\_\_\_\_\_  
 Signature of Patient/Authorized Representative

\_\_\_\_\_  
 Date signed

\_\_\_\_\_  
 Witness to Signature of Patient/Authorized Representative  
 Form #875-287 (Revised 5/2/03)

\_\_\_\_\_  
 Relationship